A Commentary on Medicare at 50

MORE YESTERDAYS THAN TOMORROWS?
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With Harry Truman watching, Lyndon Johnson brought Medicare and Medicaid to life 50 years ago this month. Recognizing Truman’s advocacy for national healthcare, LBJ staged the signing ceremony in Truman’s hometown of Independence, Missouri. Leaning over Truman, LBJ proclaimed, “We want the entire world to know that we haven’t forgotten who is the real Daddy of Medicare.”

By David W. Johnson, CEO and Founder, 4Sight Health

So began America’s experiment with national health insurance. Under Medicare, health coverage for America’s seniors has grown from under 50 percent to 96 percent. It also provides health insurance to people with permanent disabilities. Overall, the program covers 54 million Americans, a fifth of the country’s population. Medicare is fundamental to America’s social “safety net.”

While Medicare has made incremental adjustments to expand coverage and control costs, the program largely operates as originally designed with centralized payment, monitoring, and enforcement.¹

SUCCESS, BUT…

Despite its successes, Medicare’s original sins (activity-based payment and no federal interference in medical decision-making) have created an overbuilt, high-cost, acute-centric delivery system. It incentivizes overtreatment, invites manipulation, and underfunds vital care services, including behavioral health and chronic disease management.

Commercial insurers have replicated Medicare’s payment methodologies and treatment codes, which compounds the overall health system’s ineffectiveness and inefficiencies.

MEDICARE PAYMENT

Medicare employs a transparent, compliance-based payment system that separates care mechanics from care outcomes. Each March, Medicare’s Payment Advisory Commission (MedPAC) presents a mind-numbing report to Congress on Medicare Payment Policy. Last year’s 407-page report reads like the central planning document it is and includes fourteen chapters covering these topics:

- Medicare and total U.S. healthcare spending;
- MedPAC analytic framework for assessing payment adequacy;
- Fee-for-service payment updates and recommendations for each of Medicare’s nine sectors (e.g., hospitals);
- Post-acute care trend assessments;
- Updated trends in enrollment, plan offerings, and payments in Medicare Advantage plans; and
- Updated trends in Medicare Part D (drug coverage).²

Noted Princeton economist Uwe Reinhardt uses the algorithm in Figure 1 to detail Medicare’s methodology for computing inpatient reimbursement payments:³

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Figure 1. Algorithm for Calculating Medicare’s Acute Care Inpatient Payment

(For a Case with Full Lengths of Stay)

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\text{Adjustment for Geographic Hospital Wage Index} + \text{Non-Labor Related Costs of Base Case} = \text{Base Adjusted for Geographic Factors} \times \text{MS-DRG Weight} + \text{Possible, High-Cost Outlier Payment}
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Medicare’s payment algorithm is remarkably complex and easy to “game.” In theory, doctors and hospitals could maximize payment by selecting the most lucrative billing codes and providing excess care. At the margins, Medicare’s payment system rewards overtreatment and invites manipulation, even fraud. To police illicit billing activity, the system incorporates a heavy and expensive regulatory and compliance burden for both Medicare and providers. It is notable that Medicare’s algorithm omits payment for superior outcomes and penalties for inferior outcomes. To its credit, Medicare has begun incorporating some value-based criteria and readmission penalties into reimbursement payments.

The combination of Medicare’s inefficient payment mechanics with ferocious provider pursuit of reimbursement revenues makes the U.S. healthcare system the world’s most expensive one per-capita by a wide margin.

PRIVATE MARKET INNOVATION

Consumers, employers, and the marketplace are fighting back by requiring better value, more transparency, and greater convenience in healthcare delivery.

Historically, Medicare has been the principal innovator in payment and delivery reform. Current healthcare reform’s most promising feature is the extent to which private-sector innovation has leap-frogged governmental innovation (see Figure 2 at right).

Private market innovators anticipate greater customer engagement in healthcare decision-making. They believe companies delivering higher-value care will differentiate from competitors and win market share.

As it celebrates its milestone birthday, Medicare is joining healthcare’s “value” party. Earlier this year, HHS Secretary Sylvia Matthews Burwell announced Medicare’s intention to dramatically increase “risk-based payments” to providers – from under 10 percent currently to 50 and 80 percent by 2016 and 2018 respectively.

Expect expansive bundled payments for high-volume cardiac and orthopedic procedures. In fact, CMS recently announced a five-year model to study bundled payments for hip and knee replacement. As shown in Figure 3, providers are choosing from a range of escalating risk-based payment strategies.5

Spurred by societal demands for better, more affordable, and more convenient care services, the private market is propelling U.S. healthcare, including Medicare, toward value-based delivery.

Traditional Medicare is disappearing. Expanding Medicare Advantage enrollment, aggressive use of bundled payments, and more value-based purchasing link Medicare payment to efficient resource allocation and better outcomes.

WHAT SHOULD PROVIDERS DO?

Value-based payment rewards healthcare companies that deliver better, more appropriate, and convenient care at lower costs. This type of market mindset is foreign to health system managers. For decades, they have relied upon a regulatory mindset that pursues revenue optimization. Cost, outcomes, and customer satisfaction have been secondary considerations.
Given this operating reality, increasing healthcare consumerism and market pressures to deliver “value,” how should providers respond? Here are a few suggestions:

• **Avoid Digging a Deeper Hole:** Refrain from new investments and strategies predicated solely on receiving higher payment rates. If a new initiative doesn’t intrinsically provide better care at lower costs, do not pursue it.

• **Decant Routine Care to Lower-Cost Facilities:** Do not expect continuation of higher payments for routine procedures performed in high-cost settings. Respond to payer and consumer demands for more cost-effective and convenient routine care in lower-cost, distributed ambulatory facilities. Where possible, extend hours to increase access and reduce per-unit costs.

• **Standardize, Reduce Variance, and Improve Quality:** Become a true “clinical outcomes” organization. Practice care that generates the best outcomes. Quality improvement and cost reduction will follow. Publishing care outcomes increases accountability and accelerates improvement. Dr. Rick Afable, the CEO for St. Joseph Hoag Health, asks this provocative question, “Which of our patients signed up for the higher variation, lower-quality care?”

• **Understand Costs:** Deep-six cost accounting systems tied to revenues (i.e., ratio of costs to charges). Move toward time- and activity-based systems that align per-unit costs and revenues in meaningful ways.

• **Speak and Live the Truth:** Most health systems say they put patients first, but often sublimate patient needs to physician demands, reimbursement realities, and organizational inertia. Consumerism is coming to healthcare. Providers that square their operations with their rhetoric win customer trust and competitive advantage.

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**HEALTHCARE’S REAL MANAGER**

At Medicare’s inception, prominent UCLA professor Milton Roemer saw the future. He observed, “Supply may induce its own demand in the presence of third-party payment.” In other words, doctors and hospitals would create their own demand for treatments.

Fifty years later, the U.S. can no longer tolerate supply-driven demand for healthcare services. It is too expensive, too inefficient, and too error-prone.

Wish traditional Medicare a happy birthday. Also get ready to kiss it goodbye.

Demanding consumers, service-oriented providers, and user-friendly information/interface companies have enough market power to normalize healthcare’s distorted supply-demand relationships.

The true manager for Medicare and healthcare is now the market.
ABOUT HURON HEALTHCARE

Huron Healthcare is the premier provider of performance improvement and clinical transformation solutions for hospitals and health systems. In 2015, Huron acquired Studer Group, the market leader in driving healthcare cultural transformation. The combination of Huron and Studer Group is focused on improving healthcare providers' clinical, operational, and financial outcomes. By partnering with clients, Huron delivers solutions that improve quality, increase revenue, reduce expenses, and enhance physician, patient, and employee satisfaction across the healthcare enterprise. Clients include leading national and regional integrated healthcare systems, academic medical centers, community hospitals, and physician practices. Modern Healthcare ranked Huron Healthcare third on its 2014 list of the largest healthcare management consulting firms.

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ABOUT 4SIGHT HEALTH

4Sight Health is a boutique firm specializing in healthcare thought capital, strategic advisory services, and venture investing. 4Sight Health operates at the intersection of healthcare economics, strategy, and capital formation. The company’s four-stage analytics: Assess, Align, Adapt, Advance, reflects the bottom-up, evolutionary character of disruptive, market-driven change and guides 4Sight Health’s professional services, which include regular commentary on market-driven reform, public speaking, board education, strategic advice, capital formation design and execution, advancing organizational change, venture investing, and capital funding.

REFERENCES

5. Center for Medicare & Medicaid Innovation.

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